DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: RBRVS USERS:
Anesthesiologists
Advanced Registered Nurse Practitioners
Ophthalmologists
Psychiatrists
Emergency Physicians
Nurse Anesthetists
Physicians
Physician Clinics
Registered Nurse First Assistants
Family Planning Clinics
Federally Qualified Health Centers
Health Departments
Laboratories
Managed Care Plans
Podiatrists
Radiologists
Regional Administrators
CSO Administrators

Memorandum No.: 00-10 MAA
Issued: April 15, 2000

For Information Call:
1-800-562-6188

From: James C. Wilson, Assistant Secretary
Medical Assistance Administration (MAA)

Subject: **CHANGES TO RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) AND ANESTHESIOLOGY PAYMENT SYSTEMS**

Effective with dates of service on or after July 1, 2000, the Medical Assistance Administration (MAA) will:

- Implement a site of service (SOS) payment differential for professional services; and
- Revise the anesthesia payment system.

Site of Service (SOS) Payment Differential

What's Changing?

MAA is implementing a SOS payment differential for professional services provided on or after July 1, 2000, based on the Health Care Financing Administration's (HCFA) payment policy. This payment differential establishes distinct maximum allowable fees for professional services performed in facility and non-facility settings.

How are the fees established for professional services performed in the facility

and non-facility settings?

Based on the RBRVS methodology, MAA's fee schedule amounts are established using three relative value unit (RVU) components (work, practice expense and malpractice expense). Last year, HCFA began using two levels of the practice expense RVU component for many procedure codes to implement the site of service payment differential for Medicare. The resulting HCFA RVUs, published in the November 2, 1999, *Federal Register*, are being used in MAA's July 1, 2000, update. MAA will use the two levels of practice expense to determine the fee schedule amounts for reimbursing professional services beginning July 1, 2000. This may result in two RBRVS maximum allowable fees for a procedure code. These are:

- **Facility setting maximum allowable fees** (FS MAF) - Paid when the provider performs the services in a facility setting and the cost of the resources are the responsibility of the facility; or

- **Non-facility setting maximum allowable fees** (NFS MAF) - Paid for services when the provider performing the service typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the service performed.

Some services, by nature of their description, are performed only in certain settings and have only one maximum allowable fee per code. Examples of these services include many:

- Evaluation and management codes, which specify the site of service within the description of the procedure codes; and
- Major surgical procedures that are generally only performed in hospital settings.

How will the site of service payment policy affect provider reimbursements?

Providers billing professional services will be reimbursed at one of two maximum allowable fees, depending on where the service is performed. MAA's dual rates will be published in the July 1, 2000, Physician-Related Services RBRVS Billing Instructions.

Why reimburse providers differently for services performed in facility and non-facility settings?

When a provider performs a professional service in a facility setting, MAA makes two payments, one to the performing provider and another to the facility. The reimbursement to the facility includes the payment for resources. The NFS MAF includes the allowance for resources.

The professional FS MAF excludes the allowance for resources that are included in the payment to the facility. Reimbursing the lower FS MAF to performing providers when the facility is also reimbursed eliminates duplicate payment for resources.

When will <u>professional services</u> be reimbursed at the Facility Setting Maximum Allowable Fee?

Providers will be reimbursed at the FS MAF when MAA also makes a payment to a facility. MAA will follow HCFA's determination for using the FS MAF, except when this is not possible

due to system limitations.

Professional services billed with the following place of service codes will be reimbursed at the FS MAF:

MAA Place of Service Code	HCFA Place of Service Description
1	Inpatient Hospital
2	Outpatient Hospital
5	Emergency Room- Hospital
8	Skilled Nursing Facility
8	Nursing Facility
2	Hospice
1	Inpatient Psychiatric Facility
2	Psychiatric Facility Partial Hospitalization
7	Intermediate Care Facility/Mentally Retarded
1	Comprehensive Inpatient Rehabilitation Facility
2	Comprehensive Outpatient Rehabilitation Facility
2	End-Stage Renal Disease Treatment Facility

Due to Medicare consolidated billing requirements, MAA does not make a separate payment to providers who perform the certain services in hospitals and skilled nursing facilities. The facilities will be reimbursed at the NFS MAF. Some therapies, such as physical therapy services (Current Procedural Terminology (CPT) 97001-97799), will always be paid at the NFS MAF.

When will professional services be reimbursed at the Non-Facility Setting Maximum Allowable Fee?

The NFS MAF is paid when MAA does not make a separate payment to a facility. Services performed in a provider's office, client's home, facility or institution (listed in the following table) will be reimbursed at the NFS MAF. MAA will follow HCFA's determination for using the NFS MAF, except when this is not possible due to system limitations.

Professional services billed with the following place of service codes will be reimbursed at the NFS MAF:

MAA Place of Service Code	HCFA Place of Service Description

MAA Place of Service Code	HCFA Place of Service Description
3	Office *
4	Home
3	Ambulatory Surgery Center
9	Birthing Center
9	Military Treatment Facility
6	Custodial Care Facility
9	Adult Living Care Facility
3	Federally Qualified Health Center
3	Community Mental Health Center
9	Residential Substance Abuse Treatment Facility
9	Psychiatric Residential Treatment Center
3	State or Local Public Health Clinic
3	Rural Health Clinic
3	Independent Laboratory
9	Other Unlisted Facility

*Includes Neurodevelomental Centers

What <u>professional services</u> will have an SOS payment differential?

Most of the services with an SOS payment differential are from the surgery, medicine and evaluation and management ranges of CPT. However, some HCPCS, CPT radiology, pathology and laboratory codes also have an SOS payment differential.

<u>Anesthesiology</u>

What's changing?

Effective with dates of service on or after July 1, 2000:

- Changing the source of anesthesia base units;
- Coding for anesthesia;
- Calculating time units used for reimbursement;
- Determining total time for obstetric epidurals;
- Adopting Medicare's policy regarding surgeons administering anesthesia; and
- Adopting Medicare's policy regarding discontinuous anesthesia.

What will be the source of anesthesia base units?

Effective with dates of service on or after July 1, 2000, the current American Society of Anesthesiologist's *Relative Value Guide* (ASA RVG) will serve as the primary source for

anesthesia base units.

Currently, anesthesia base units are adopted from St. Anthony's *Relative Values for Physicians*. Since St. Anthony's base units are generally derived from the base units published by the American Society of Anesthesiologists, this change should have little impact on the base units for most anesthesia services. We will continue to seek input from the Anesthesiology Technical Advisory Group (ATAG) when necessary after adoption of the ASA RVG.

What procedure codes should be used to bill for anesthesia services?

Effective with dates of service on or after July 1, 2000, MAA will require providers to use Anesthesia CPT 2000 codes 00100 through 01999 to bill for anesthesia services paid with base and time units. In addition to the Anesthesia CPT 2000 codes, MAA will accept two anesthesia codes published in the ASA RVG:

ASA Code	ASA RVG Description
01951	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider)
01952	Anesthesia for diagnostic or therapeutic nerve blocks and injections- patient in the prone position (when block or injection is performed by a different provider)

These ASA codes are to be used only when a provider, other than the one performing the block or the injection, administers anesthesia. MAA will not adopt any other ASA RVG codes that are not included in CPT. All other anesthesia codes should be billed according to the descriptions published in CPT. When there are differences in code descriptions between CPT and ASA RVG, MAA will follow CPT descriptions. MAA will no longer reimburse for anesthesia services when billed with the CPT surgery, radiology and medicine codes. **Continue to use the appropriate anesthesia modifier with Anesthesia CPT and ASA codes.**

> Exception: Continue to bill CPT Pain Management/Other Services codes (refer to page F21 in your Physician-Related Services RBRVS Billing Instructions for specific procedures) that are not paid with base and time units. These services will be reimbursed as a procedure using RBRVS methodology. Do not bill time in the units field or use anesthesia modifiers.

Claims submitted to MAA with CPT surgery, radiology and medicine codes for anesthesia services reimbursed using base and time units for dates of service on or after July 1, 2000 will be denied.

MAA is mandated by HCFA to obtain consent forms from physicians and anesthesiologists when vasectomies, sterilizations, and hysterectomies are performed. MAA needs to distinguish voluntary termination of pregnancy including complications for managed care clients in order to

pay using fee-for-service. MAA maintains client confidentiality and does not bill a third party insurance for abortions for non-managed care clients.

Because multiple CPT surgery codes cross to only one anesthesia CPT code, it is not possible for MAA to identify when the anesthesia CPT codes are being billed for vasectomies, sterilizations, hysterectomies, or abortions. For this reason, MAA has created five state-unique anesthesia codes for these procedures. Bill the appropriate anesthesia modifier with the anesthesia state-unique code. When billing abortion code 5915M, indicate in Box 19 of the HCFA claim form or in the Comments field for direct entry, magnetic tape or EMC "voluntary or induced abortion." Below are the state-unique anesthesia codes with associated CPT surgical codes that must be used:

Procedure	State-Unique Code	CPT Codes
Vasectomies	5911M	54690, 55250, and 55450
Sterilizations	5912M	58600, 58605, 58611, 58615, 58670 and 58671
Hysterectomies	5913M	51925, 58150, 58152, 58180, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58550 and 59135
Hysterectomies	5914M	58200, 58210, 58240, 58285 and 59525
Abortions	5915M	59812, 59820, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856 and 59857

Anesthesia CPT 2000 codes 00855 and 00944 are not covered.

How will my anesthesia payment be calculated?

Currently, anesthesia reimbursement is based on 12-minute time units. However, Medicare and most other payers reimburse for anesthesia using 15-minute time units.

Effective with dates of service on or after July 1, 2000, MAA will change anesthesia reimbursement to 15-minute time units rather than 12-minute time units. This change does not affect how providers bill for services, only how anesthesia reimbursements are *calculated*. Providers should continue to report the total anesthesia minutes calculated to the next whole minute in the units field.

The following table illustrates how the anesthesia payment calculation will change:

Current Payment Calculation *(for dates of service through June 30, 2000)*	**New Payment Calculation** *(for dates of service on or after July 1, 2000)*
A. Multiply base units by **12**	**A.** Multiply base units by **15**
B. Add total minutes to value from step A	**B.** Add total minutes to value from step A
C. Divide anesthesia conversion factor by 12 to obtain the rate per minute.	**C.** Divide anesthesia conversion factor by 15 to obtain the rate per minute.

D. Multiply total from step B by the rate per minute in Step C.	**D.** Multiply total from step B by the rate per minute in Step C.

How do I determine total anesthesia time for obstetric epidurals?

During normal labor and delivery and C-sections, time begins with anesthesia insertion and ends with removal, for a maximum of 6 hours per delivery.

To calculate reimbursement, the base unit plus total time (insertion through delivery and removal, subject to a 6-hour cap) is multiplied by the anesthesia conversion factor that has been divided by 15 or 12 depending on the date of service.

What is Medicare's policy regarding surgeons administering anesthesia?

Currently, anesthesia services performed by surgeons are reported with CPT modifier –47. Under Medicare's payment policy, **separate reimbursement** for local, regional, or digital block or general anesthesia administered by the surgeon **is not allowed**. These services are considered included in the RBRVS payment for the procedure.

Effective for dates of service on or after July 1, 2000, MAA will follow HCFA's policy and not reimburse surgeons for anesthesia services. Bills for anesthesia services with modifier –47 will be denied.

What is Medicare's policy regarding discontinuous anesthesia?

Currently anesthesia time begins with the physical preparation for the induction of anesthesia and ends when the anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) is no longer in constant attendance.

Medicare's revised policy allows providers to sum up blocks of time around a break in continuous anesthesia care, as long as there is continuous monitoring of the patient within the blocks of time. The revised payment policy does not alter the fundamental principle that anesthesia time represents a continuous block of time when a patient is under the care of an anesthesiologist or CRNA. It continues to not allow billing of time units for the pre-anesthesia exam and evaluation as these services are included as part of the base unit component.

Effective with dates of service on or after July 1, 2000, MAA will follow Medicare's revised policy regarding discontinuous anesthesia.

The above changes listed in this numbered memorandum will be published in the July 1, 2000 Physician-Related Services RBRVS Billing Instructions.